REGULAR COUNCIL MEETING

A G E N D A

TOWN OF CHINCOTEAGUE

June 18, 2009 - 6:00 P.M. - Council Chambers - Town Hall

CALL TO ORDER

INVOCATION BY COUNCILMAN J. HOWARD

PLEDGE OF ALLEGIANCE

OPEN FORUM / PUBLIC PARTICIPATION

AGENDA ADDITIONS/DELETIONS AND ADOPTION:

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1. Consider a Change in Healthcare Providers (Bill McComb)

2. Presentation of the Down Town Revitalization Project (Clay Massey)

3. Public Hearing for the Fiscal Year "2010" Budget, Consisting of; **(Page 8 of 38)**

• Revenues for all Divisions	• Trolley Division Expenses
• General Government Fund Expenses	• Harbor Division Expenses
• Water Division Expenses	• Harbor, Water, & Gen Gov. Rate Sheets
• Total Main Street Fund Expenses	

4. Resolution of Respect for the former Town Councilman William Elliot **(Page 35 of 38)**

5. Resolution for a Virginia Litter Prevention and Recycling Grant **(Page 35 of 38)**

6. Curtis Merritt Harbor of Refuge Project Change Order Request **(Page 35 of 38)**

7. Presentation of Reverse 911 (Randy Mills) **(Page 22 of 38)**

8. Possible Wind Energy Ordinance (Jared Anderson) **(Page 23 of 38)**

9. Street Name Request **(Page 27 of 38)**

10. Library Availability fee Waiver Request (Vice-Mayor Jester) **(Page 28 of 38)**

11. Administrative Fee for Building without a Permit (Councilman Frese) **(Page 31 of 38)**

12. Mayor & Council Announcements or Comments
    (Note: Roberts Rules do not allow for discussion under comment period)

ADJOURN:

Optima Plus
15/90%
Small Group
Summary of Benefits

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions.

You have the choice of using In-Network or Out of Network benefits for most benefits. To use Your In-Network benefits all covered services must be received from Plan Providers. All Covered Services received from Non Plan Providers will be covered under Out-of-Network benefits. All covered laboratory services received from Non Plan laboratories will be covered under Out-of-Network benefits. Covered Services received from Non-Plan Providers while the Member is receiving care at plan facilities will be covered under Out-of-Network benefits.

	In-Network Coverage	*Out-of-Network Coverage*
Maximum Plan Benefit[1]	Not Applicable	$3,000,000
Deductibles per Calendar Year[2]	Not Applicable	$200 per Member $400 per Family
Maximum Out-of-Pocket Amount per Calendar Year	$1,000 per Member[3] $2,000 per Family[3]	$4,000 per Member[4] $8,000 per Family[4]

PHYSICIAN SERVICES

Pre-Authorization is required for in-office surgery.[5]
Copayment or Coinsurance applies to Covered Services performed in the Physician's office. An additional Copayment or Coinsurance may apply to outpatient therapy and rehabilitative services, and outpatient advanced imaging procedures done in the physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Primary Care Physician (PCP) Office Visit	$15 Copayment then covered at 100%[8]	After Deductible covered at 80%[AC]
Specialist Office Visit	$25 Copayment then covered at 100%[8]	After Deductible covered at 80%[AC]

Preventive Care Visits	In-Network Coverage	Out-of-Network Coverage
Routine Annual Physical Exams **Well Baby Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations**	$15 Copayment	After Deductible covered at 80%[AC]
Screening Colonoscopy **Screening Mammograms** An outpatient diagnostic copayment or coinsurance will apply to any diagnostic procedures performed during routine screenings.	Covered at 100%[8]	After Deductible covered at 80%[AC]
Vaccines and Immunotherapeutic Agents Member is responsible for Coinsurance amount up to a maximum copayment amount of $250 per dose.	Covered at 50%[8]	After Deductible covered at 50%[AC]

SHORT TERM OUTPATIENT THERAPY AND REHABILITATION SERVICES[5,6]

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Outpatient Therapy Services	*In-Network Coverage*	*Out-of-Network Coverage*
Physical Therapy **Occupational Therapy** **Speech Therapy** **Pre-Authorization is required.[5]** Limited to a maximum combined benefit with out-of-network benefits of 90 consecutive days per condition per lifetime.[6]	$15 Copayment per PCP office visit $25 Copayment per Specialist office visit Covered at 90%[8] per outpatient facility visit	After Deductible covered at 80%[AC]

Outpatient Rehabilitation Services	*In-Network Coverage*	*Out-of-Network Coverage*
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[5] Limited to a maximum combined benefit with out-of-network benefits of 90 consecutive days per condition per lifetime.[6]	$15 Copayment per PCP office visit $25 Copayment per Specialist office visit Covered at 90%[8] per outpatient facility visit	After Deductible covered at 80%[AC]

OTHER OUTPATIENT TREATMENTS[6]

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Other Outpatient Treatments	*In-Network Coverage*	*Out-of-Network Coverage*
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy** **Pre-Authorization is required for IV Therapy with medications and inhalation therapy.** [5]	$15 Copayment per PCP office visit $25 Copayment per Specialist office visit Covered at 90%[8] per outpatient facility visit	After Deductible covered at 80%[AC]

OUTPATIENT DIALYSIS SERVICES

	In-Network Coverage	*Out-of-Network Coverage*
Dialysis Services	Covered at 90%[8] Copayment or Coinsurance applies regardless of place of service.	After Deductible covered at 80%[AC]

OUTPATIENT SURGERY [5]

Coinsurance applies to services provided in a freestanding ambulatory surgery center or Hospital outpatient surgical facility.

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Surgery **Pre-Authorization is required.** [5]	$100 Copayment then covered at 90% [8]	After Deductible covered at 80%[AC]

OUTPATIENT DIAGNOSTIC PROCEDURES [5]

Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.

	In-Network Coverage	*Out-of-Network Coverage*
Diagnostic Procedures **Pre-Authorization is required.**[5]	Covered at 90%[8]	After Deductible covered at 80%[AC]
X-Ray **Ultrasound** **Doppler Studies.**	Covered at 90%[8]	After Deductible covered at 80%[AC]
Outpatient Lab Work	Covered at 90%[8]	After Deductible covered at 80%[AC]

OUTPATIENT ADVANCED IMAGING PROCEDURES

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility or in a physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Pre-Authorization is required.[5] **Magnetic Resonance Imaging (MRI)** **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)**	Covered at 90%[8]	After Deductible covered at 80%[AC]

MATERNITY CARE [5,10]

Copayment or Coinsurance is in addition to any applicable inpatient hospital admission Copayment or Coinsurance.
Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage unless covered under a Rider.

	In-Network Coverage	*Out-of-Network Coverage*
Maternity Care **Pre-Authorization required for prenatal services.** [5]	Covered at 90%[8]	After Deductible covered at 80%[AC]

INPATIENT SERVICES [5,6]

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Hospital Services **Transplants are covered at <u>contracted</u> facilities only.**	$300 Inpatient Copayment per admission then covered at 90%[8]	After Deductible covered at 80%[AC]
Skilled Nursing Facilities/Services[5] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined in and out of network per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Facility Services. [6]	Covered at 90%[8] after inpatient hospital Copayment has been met.	After Deductible covered at 80%[AC]

AMBULANCE SERVICES [9]

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

	In-Network Coverage	*Out-of-Network Coverage*
Ambulance Services **Pre-Authorization is required for use other than for emergency services.** [5]	$25 Copayment for transport each way then covered at 90%[8]	Same as In-Network Benefit

EMERGENCY DEPARTMENT SERVICES [9]

Includes those emergency Department facility, physician, and ancillary services that are rendered during an emergency visit. If the Member requires inpatient hospital admission the Member will be responsible for the applicable inpatient hospital admission Copayment or Coinsurance.

	In-Network Coverage	*Out-of-Network Coverage*
Emergency Department Services **A referral is <u>not</u> required.** **Pre-Authorization is <u>not</u> required.**	$100 Copayment then covered at 90%[8] Benefit reduction to 50%[8] for non-emergency use of facilities.	Same as In-Network Benefit Benefit reduction to 50%[8] for non-emergency use of facilities.

URGENT CARE CENTER SERVICES [9]

	In-Network Coverage	*Out-of-Network Coverage*
Urgent Care Center Services **A referral is <u>not</u> required.** **Pre-Authorization is <u>not</u> required.** Includes urgent care center services, primary care and specialist physician services, and other ancillary services received at an Urgent Care center. If you are transferred to an emergency room from an urgent care center, you will be responsible for any applicable emergency room Copayment or Coinsurance.	$25 Copayment	After Deductible covered at 80%[AC] (for non-emergency services only)

MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Services **Pre-Authorization is required.** [5]	$300 Inpatient Copayment per admission then covered at 90%[8]	After Deductible covered at 80%[AC]
Outpatient Services **Pre-Authorization is required for outpatient psychological testing.** [5]	$25 Copayment per outpatient visit.	After Deductible covered at 80%[AC]
Employee Assistance Program (EAP)	$0 Copayment for up to three Employee Assistance Program (EAP) visits per presenting issue according to treatment protocols.	Covered In-network only from Participating EAP providers.

OTHER COVERED SERVICES

	In-Network Coverage	*Out-of-Network Coverage*
Artificial Limb Services [5,6] **Pre-Authorization is required.** For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per occurrence for a maximum of two occurrences.[6]	Covered at 90%[8]	After Deductible covered at 80%[AC]
Chiropractic Care [6] **Administered by American Specialty Health Networks (ASHN).** Coverage is limited to a combined maximum benefit with in and out of network benefits of $500 per Member, per calendar year. Chiropractic appliances are covered up to $50 maximum benefit per Member per calendar year when medically necessary. For providers not in the ASHN network the Member will be responsible for payment of all charges in excess of ASHN's allowable charge in addition to any coinsurance amount listed at left. Allowable charge is the lesser of the provider's actual charge or ASHN's in-network fee schedule for the same services.	Covered at 80% of ASHN fee schedule	Covered at 60% of ASHN fee schedule

Diabetic Supplies and Equipment Includes FDA-approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Note: Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.	Covered at 90%[8] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. Covered at 90%[8] for insulin pumps. Covered at 90%[8] for outpatient self-management training and education, including medical nutritional therapy.	After Deductible covered at 80%[AC]
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.[5]** **Pre-Authorization is required for all rental items.[5]** **Pre-Authorization is required for all repair and replacement.[5]** Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement. Coverage is limited to $3,000 combined in-network and out-of-network per member per calendar year.[6]	Covered at 90%[8]	After Deductible covered at 80%[AC]
Early Intervention Services. **Pre-Authorization is required.[5]** Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices . **Coverage is limited to $5,000 per Member per calendar year.**	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service
Home Health Care Skilled Services [5,6] **Pre-Authorization required[5]** A member must be homebound and unable to receive services outside the home to receive care. An outpatient therapy Copayment or Coinsurance will apply to physical, occupational, and speech therapy received in the home.	Covered at 90%[8] Maximum combined benefit with Out-of-Network benefit of 100 visits per calendar year.	After Deductible covered at 80%[AC] Maximum combined benefit with In-Network benefits of 100 visits per calendar year.
Hospice Care **Pre-Authorization is required.[5]**	Covered at 90%[8]	After Deductible covered at 80%[AC]

Preventive Vision Services **Administered by EyeMed Vision Services.** Covered for one examination every 24 months performed by a Participating EyeMed Provider	$15 Copayment per eye examination once every 24 months. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost	$30 reimbursement for exam only
Reduction Mammoplasty Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.	Covered at 50%[8]	After Deductible covered at 50% [AC]

NOTES

The Covered Services herein are subject to the terms and conditions set forth in the Certificate of Insurance form number OHIC.PPO.COI.7.08

1. Maximum benefits payable under the Plan.
2. Deductible means the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. A Plan may have a separate deductible for in network services and for out of network services. Any such amount will not be reimbursed under the Plan. Any part of the calendar year deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year. Amounts which a member is required to pay for outpatient prescription drugs, preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Physician office visits and the Member is required to pay applicable office visit Copayment only. Amounts applied to an in-network deductible will apply toward the Plan's in-network out of pocket maximum amount. Amounts applied to an out-of-network deductible will apply toward the Plan's out of network out of pocket maximum amount.
3. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less except vaccines, or amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures do not count toward the In-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The Out-Of-Network Deductible does not apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for Out-Of-Network Covered Services do not count toward the In-Network Out-Of-Pocket Maximum.
4. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered Out-of-Network Services. The Out-Of-Network Deductible will apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less except vaccines, amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-Of-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The In-Network Deductible does not apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for In-Network Covered Services do not count toward the Out-Of-Network Out-Of-Pocket Maximum.
5. Pre-Authorization is required. A Member's benefits under the policy will be reduced, after any deductible amount, if he/she does not comply with the Plan's referral and pre-authorization procedures. Details concerning the Plan's referral and pre-authorization procedures, including possible benefit reductions for not following the requirements, are provided under Section III in the Certificate of Insurance. If a Member does not properly follow the Plan's Pre-Authorization procedures and ensure that the provider/physician has obtained Pre-Authorization when it is required, and the Plan determines through Retrospective Review that the Covered Service was Medically Necessary, the Plan will apply a $500 fee which will be offset against any benefit owed by the Plan. The penalty fee with not count toward any Plan Deductible or maximum out of pocket amounts.
6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Schedule of Benefits or added by a Plan rider are excluded from Coverage.
7. N/A.
8. Benefits are payable at the percent specified of the Plan's fee schedule.
9. All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the benefit will be reduced as specified on the Schedule of Benefits. Members who receive Emergency services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the emergency care been received from Plan Providers. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.
10. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.

Optima Plus
500/25/80%
Summary of Benefits

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You have the choice of using In-Network or Out of Network benefits for most benefits. To use Your In-Network benefits all covered services must be received from Plan Providers. All Covered Services received from Non Plan Providers will be covered under Out-of-Network benefits. All covered laboratory services received from Non Plan laboratories will be covered under Out-of-Network benefits. Covered Services received from Non-Plan Providers while the Member is receiving care at plan facilities will be covered under Out-of-Network benefits.

	In-Network Coverage	*Out-of-Network Coverage*
Maximum Plan Benefit[1]	Not Applicable	$3,000,000
Deductibles per Calendar Year[2]	$500 per Member $1,000 per Family	$750 per Member $1,500 per Family
Maximum Out-of-Pocket Amount per Calendar Year	$2,500 per Member[3] $5,000 per Family[3]	$7,500 per Member[4] $15,000 per Family[4]

PHYSICIAN SERVICES

Pre-Authorization is required for in-office surgery.[5]
Copayment or Coinsurance applies to Covered Services performed in the Physician's office. An additional Copayment or Coinsurance may apply to outpatient therapy and rehabilitative services, and outpatient advanced imaging procedures done in the physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Primary Care Physician (PCP) Office Visit	$25 Copayment then covered at 100%[8]	After Deductible covered at 60%[AC]
Specialist Office Visit	$40 Copayment then covered at 100%[8]	After Deductible covered at 60%[AC]

Preventive Care Visits	In-Network Coverage	Out-of-Network Coverage
Routine Annual Physical Exams **Well Baby Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations**	$25 Copayment	After Deductible covered at 60%[AC]
Screening Colonoscopy **Screening Mammograms** An outpatient diagnostic copayment or coinsurance will apply to any diagnostic procedures performed during routine screenings.	Covered at 100%[8]	After Deductible covered at 60%[AC]
Vaccines and Immunotherapeutic Agents Member is responsible for Coinsurance amount up to a maximum copayment amount of $250 per dose.	After Deductible covered at 50%[8]	After Deductible covered at 50%[AC]

SHORT TERM OUTPATIENT THERAPY AND REHABILITATION SERVICES[5,6]

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Outpatient Therapy Services	*In-Network Coverage*	*Out-of-Network Coverage*
Physical Therapy **Occupational Therapy** **Speech Therapy** **Pre-Authorization is required.[5]** Limited to a maximum combined benefit with out-of-network benefits of 90 consecutive days per condition per lifetime.[6]	$25 Copayment per PCP office visit $40 Copayment per Specialist office visit After Deductible covered at 80%[8] per outpatient facility visit	After Deductible covered at 60%[AC]

Outpatient Rehabilitation Services	*In-Network Coverage*	*Out-of-Network Coverage*
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[5] Limited to a maximum combined benefit with out-of-network benefits of 90 consecutive days per condition per lifetime.[6]	$25 Copayment per PCP office visit $40 Copayment per Specialist office visit After Deductible covered at 80%[8] per outpatient facility visit	After Deductible covered at 60%[AC]

OTHER OUTPATIENT TREATMENTS[6]

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Other Outpatient Treatments	*In-Network Coverage*	*Out-of-Network Coverage*
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy** **Pre-Authorization is required for IV Therapy with medications and inhalation therapy.**[5]	$25 Copayment per PCP office visit $40 Copayment per Specialist office visit After Deductible covered at 80%[8] per outpatient facility visit	After Deductible covered at 60%[AC]

OUTPATIENT DIALYSIS SERVICES

	In-Network Coverage	*Out-of-Network Coverage*
Dialysis Services	After Deductible covered at 80%[8] Copayment or Coinsurance applies regardless of place of service.	After Deductible covered at 60%[AC]

OUTPATIENT SURGERY [5]

Coinsurance applies to services provided in a freestanding ambulatory surgery center or Hospital outpatient surgical facility.

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Surgery **Pre-Authorization is required.** [5]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]

OUTPATIENT DIAGNOSTIC PROCEDURES [5]

Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.

	In-Network Coverage	*Out-of-Network Coverage*
Diagnostic Procedures **Pre-Authorization is required.**[5]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
X-Ray **Ultrasound** **Doppler Studies.**	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
Outpatient Lab Work	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]

OUTPATIENT ADVANCED IMAGING PROCEDURES

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility or in a physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Pre-Authorization is required.[5] **Magnetic Resonance Imaging (MRI)** **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)**	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]

MATERNITY CARE [5,10]

Copayment or Coinsurance is in addition to any applicable inpatient hospital admission Copayment or Coinsurance.
Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage unless covered under a Rider.

	In-Network Coverage	*Out-of-Network Coverage*
Maternity Care **Pre-Authorization required for prenatal services.** [5]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]

INPATIENT SERVICES [5,6]

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Hospital Services **Transplants are covered at <u>contracted</u> facilities only.**	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
Skilled Nursing Facilities/Services[5] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined in and out of network per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Facility Services. [6]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]

AMBULANCE SERVICES [9]

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

	In-Network Coverage	*Out-of-Network Coverage*
Ambulance Services **Pre-Authorization is required for use other than for emergency services.** [5]	After Deductible $25 Copayment for transport each way then covered at 80%[8]	Same as In-Network Benefit

EMERGENCY DEPARTMENT SERVICES [9]

Includes those emergency Department facility, physician, and ancillary services that are rendered during an emergency visit. If the Member requires inpatient hospital admission the Member will be responsible for the applicable inpatient hospital admission Copayment or Coinsurance.

	In-Network Coverage	*Out-of-Network Coverage*
Emergency Department Services **A referral is <u>not</u> required.** **Pre-Authorization is <u>not</u> required.**	After Deductible covered at 80%[8] Benefit reduction to 50%[8] for non-emergency use of facilities.	Same as In-Network Benefit Benefit reduction to 50%[8] for non-emergency use of facilities.

URGENT CARE CENTER SERVICES [9]

	In-Network Coverage	*Out-of-Network Coverage*
Urgent Care Center Services **A referral is <u>not</u> required.** **Pre-Authorization is <u>not</u> required.** Includes urgent care center services, primary care and specialist physician services, and other ancillary services received at an Urgent Care center. If you are transferred to an emergency room from an urgent care center, you will be responsible for any applicable emergency room Copayment or Coinsurance.	$40 Copayment	After Deductible covered at 60%[AC] (for non-emergency services only)

MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Services **Pre-Authorization is required.** [5]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
Outpatient Services **Pre-Authorization is required for outpatient psychological testing.** [5]	$30 Copayment per outpatient visit.	After Deductible covered at 60%[AC]
Employee Assistance Program (EAP)	$0 Copayment for up to three Employee Assistance Program (EAP) visits per presenting issue according to treatment protocols.	Covered In-network only from Participating EAP providers.

OTHER COVERED SERVICES		
	In-Network Coverage	***Out-of-Network Coverage***
Artificial Limb Services [5,6] **Pre-Authorization is required.** For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per occurrence for a maximum of two occurrences.[6]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
Chiropractic Care [6] **Administered by American Specialty Health Networks (ASHN).** Coverage is limited to a combined maximum benefit with in and out of network benefits of $500 per Member, per calendar year. Chiropractic appliances are covered up to $50 maximum benefit per Member per calendar year when medically necessary. For providers not in the ASHN network the Member will be responsible for payment of all charges in excess of ASHN's allowable charge in addition to any coinsurance amount listed at left. Allowable charge is the lesser of the provider's actual charge or ASHN's in-network fee schedule for the same services.	Covered at 80% of ASHN fee schedule	Covered at 60% of ASHN fee schedule

Diabetic Supplies and Equipment Includes FDA-approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Note: Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.	After Deductible covered at 80%[8] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. After Deductible covered at 80%[8] for insulin pumps. After Deductible covered at 80%[8] for outpatient self-management training and education, including medical nutritional therapy.	After Deductible covered at 60%[AC]
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.**[5] **Pre-Authorization is required for all rental items.**[5] **Pre-Authorization is required for all repair and replacement.**[5] Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement. Coverage is limited to $3,000 combined in-network and out-of-network per member per calendar year.[6]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
Early Intervention Services. **Pre-Authorization is required.**[5] Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices . **Coverage is limited to $5,000 per Member per calendar year.**	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service
Home Health Care Skilled Services [5,6] **Pre-Authorization required**[5] A member must be homebound and unable to receive services outside the home to receive care. An outpatient therapy Copayment or Coinsurance will apply to physical, occupational, and speech therapy received in the home.	After Deductible covered at 80%[8] Maximum combined benefit with Out-of-Network benefit of 100 visits per calendar year.	After Deductible covered at 60%[AC] Maximum combined benefit with In-Network benefits of 100 visits per calendar year.

Hospice Care **Pre-Authorization is required.**[5]	After Deductible covered at 80%[8]	After Deductible covered at 60%[AC]
Preventive Vision Services **Administered by EyeMed Vision Services.** Covered for one examination every 24 months performed by a Participating EyeMed Provider	$15 Copayment per eye examination once every 24 months. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost	$30 reimbursement for exam only
Reduction Mammoplasty Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.	After Deductible covered at 50%[8]	After Deductible covered at 50%[AC]

NOTES

The Covered Services herein are subject to the terms and conditions set forth in the Certificate of Insurance form number OHIC.PPO.COI.7.08

1. Maximum benefits payable under the Plan.
2. Deductible means the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. A Plan may have a separate deductible for in network services and for out of network services. Any such amount will not be reimbursed under the Plan. Any part of the calendar year deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year. Amounts which a member is required to pay for outpatient prescription drugs, preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Physician office visits and the Member is required to pay applicable office visit Copayment only. Amounts applied to an in-network deductible will apply toward the Plan's in-network out of pocket maximum amount. Amounts applied to an out-of-network deductible will apply toward the Plan's out of network out of pocket maximum amount.
3. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less except vaccines, or amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures do not count toward the In-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The Out-Of-Network Deductible does not apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for Out-Of-Network Covered Services do not count toward the In-Network Out-Of-Pocket Maximum.
4. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered Out-of-Network Services. The Out-Of-Network Deductible will apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less except vaccines, amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-Of-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The In-Network Deductible does not apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for In-Network Covered Services do not count toward the Out-Of-Network Out-Of-Pocket Maximum.
5. Pre-Authorization is required. A Member's benefits under the policy will be reduced, after any deductible amount, if he/she does not comply with the Plan's referral and pre-authorization procedures. Details concerning the Plan's referral and pre-authorization procedures, including possible benefit reductions for not following the requirements, are provided under Section III in the Certificate of Insurance. If a Member does not properly follow the Plan's Pre-Authorization procedures and ensure that the provider/physician has obtained Pre-Authorization when it is required, and the Plan determines through Retrospective Review that the Covered Service was Medically Necessary, the Plan will apply a $500 fee which will be offset against any benefit owed by the Plan. The penalty fee with not count toward any Plan Deductible or maximum out of pocket amounts.
6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Schedule of Benefits or added by a Plan rider are excluded from Coverage.
7. N/A.
8. Benefits are payable at the percent specified of the Plan's fee schedule.
9. All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the benefit will be reduced as specified on the Schedule of Benefits. Members who receive Emergency services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the emergency care been received from Plan Providers. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.
10. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.

Optima Plus
1750/30/70%
Summary of Benefits

This document is not a contract or policy with Optima Health. It is a summary of benefits and services available through the Plan. If there are any differences between this summary and the employer group plan Evidence of Coverage or Certificate of Insurance, the provisions of those documents will prevail for all benefits, conditions, limitations and exclusions.

You have the choice of using In-Network or Out of Network benefits for most benefits. To use Your In-Network benefits all covered services must be received from Plan Providers. All Covered Services received from Non Plan Providers will be covered under Out-of-Network benefits. All covered laboratory services received from Non Plan laboratories will be covered under Out-of-Network benefits. Covered Services received from Non-Plan Providers while the Member is receiving care at plan facilities will be covered under Out-of-Network benefits.

	In-Network Coverage	*Out-of-Network Coverage*
Maximum Plan Benefit[1]	Not Applicable	$3,000,000
Deductibles per Calendar Year[2]	$1,750 per Member $3,500 per Family	$2,000 per Member $4,000 per Family
Maximum Out-of-Pocket Amount per Calendar Year	$5,000 per Member[3] $10,000 per Family[3]	$10,000 per Member[4] $20,000 per Family[4]

PHYSICIAN SERVICES

Pre-Authorization is required for in-office surgery.[5]
Copayment or Coinsurance applies to Covered Services performed in the Physician's office. An additional Copayment or Coinsurance may apply to outpatient therapy and rehabilitative services, and outpatient advanced imaging procedures done in the physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Primary Care Physician (PCP) Office Visit	$30 Copayment then covered at 100%[8]	After Deductible covered at 50%[AC]
Specialist Office Visit	$30 Copayment then covered at 100%[8]	After Deductible covered at 50%[AC]

Preventive Care Visits	In-Network Coverage	Out-of-Network Coverage
Routine Annual Physical Exams **Well Baby Exams** **Annual Gyn Exams and Pap Smears** **PSA Tests** **Colorectal Cancer Tests** **Routine Adult and Childhood Immunizations**	$30 Copayment	After Deductible covered at 50%[AC]
Screening Colonoscopy **Screening Mammograms** An outpatient diagnostic copayment or coinsurance will apply to any diagnostic procedures performed during routine screenings.	Covered at 100%[8]	After Deductible covered at 50%[AC]
Vaccines and Immunotherapeutic Agents Member is responsible for Coinsurance amount up to a maximum copayment amount of $250 per dose.	After Deductible covered at 50%[8]	After Deductible covered at 50%[AC]

SHORT TERM OUTPATIENT THERAPY AND REHABILITATION SERVICES[5,6]

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Outpatient Therapy Services	*In-Network Coverage*	*Out-of-Network Coverage*
Physical Therapy **Occupational Therapy** **Speech Therapy** **Pre-Authorization is required.[5]** Limited to a maximum combined benefit with out-of-network benefits of 90 consecutive days per condition per lifetime.[6]	$30 Copayment per PCP office visit $30 Copayment per Specialist office visit After Deductible covered at 70%[8] per outpatient facility visit	After Deductible covered at 50%[AC]

Outpatient Rehabilitation Services	*In-Network Coverage*	*Out-of-Network Coverage*
Cardiac Rehabilitation **Pulmonary Rehabilitation** **Vascular Rehabilitation** **Vestibular Rehabilitation** **Pre-Authorization is required.**[5] Limited to a maximum combined benefit with out-of-network benefits of 90 consecutive days per condition per lifetime.[6]	$30 Copayment per PCP office visit $30 Copayment per Specialist office visit After Deductible covered at 70%[8] per outpatient facility visit	After Deductible covered at 50%[AC]

OTHER OUTPATIENT TREATMENTS[6]

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility, a Physician's office, or in the Member's home as part of Skilled Home Health Care Services benefit.

Other Outpatient Treatments	*In-Network Coverage*	*Out-of-Network Coverage*
Chemotherapy **Radiation Therapy** **IV Therapy** **Inhalation Therapy** **Pre-Authorization is required for IV Therapy with medications and inhalation therapy.** [5]	$30 Copayment per PCP office visit $30 Copayment per Specialist office visit After Deductible covered at 70%[8] per outpatient facility visit	After Deductible covered at 50%[AC]

OUTPATIENT DIALYSIS SERVICES

	In-Network Coverage	*Out-of-Network Coverage*
Dialysis Services	After Deductible covered at 70%[8] Copayment or Coinsurance applies regardless of place of service.	After Deductible covered at 50%[AC]

OUTPATIENT SURGERY [5]

Coinsurance applies to services provided in a freestanding ambulatory surgery center or Hospital outpatient surgical facility.

	In-Network Coverage	*Out-of-Network Coverage*
Outpatient Surgery **Pre-Authorization is required.** [5]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]

OUTPATIENT DIAGNOSTIC PROCEDURES [5]

Copayment or Coinsurance will apply when a procedure is performed in a free-standing outpatient facility or lab, or a hospital outpatient facility or lab.

	In-Network Coverage	*Out-of-Network Coverage*
Diagnostic Procedures **Pre-Authorization is required.**[5]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
X-Ray **Ultrasound** **Doppler Studies.**	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
Outpatient Lab Work	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]

OUTPATIENT ADVANCED IMAGING PROCEDURES

Copayment or Coinsurance applies to Covered Services provided in a free-standing outpatient facility, hospital outpatient facility or in a physician's office.

	In-Network Coverage	*Out-of-Network Coverage*
Pre-Authorization is required.[5] **Magnetic Resonance Imaging (MRI)** **Magnetic Resonance Angiography (MRA)** **Positron Emission Tomography (PET Scans)** **Computerized Axial Tomography (CT Scans)** **Computerized Axial Tomography Angiogram (CTA Scans)**	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]

MATERNITY CARE [5,10]

Copayment or Coinsurance is in addition to any applicable inpatient hospital admission Copayment or Coinsurance.
Coverage for any maternity related services for obstetrical, prenatal, perinatal, or post-partum care for a Dependent child is excluded from Coverage unless covered under a Rider.

	In-Network Coverage	*Out-of-Network Coverage*
Maternity Care **Pre-Authorization required for prenatal services.** [5]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]

INPATIENT SERVICES [5,6]

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Hospital Services **Transplants are covered at <u>contracted</u> facilities only.**	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
Skilled Nursing Facilities/Services[5] Following inpatient hospital care or in lieu of hospitalization. Covered Services include up to 100 days combined in and out of network per calendar year per illness or condition that in the Plan's judgment requires Skilled Nursing Facility Services. [6]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]

AMBULANCE SERVICES [9]

For emergency transportation, or as Medically Necessary and Pre-Authorized by the Plan.

	In-Network Coverage	*Out-of-Network Coverage*
Ambulance Services **Pre-Authorization is required for use other than for emergency services.** [5]	After Deductible $25 Copayment for transport each way then covered at 70%[8]	Same as In-Network Benefit

EMERGENCY DEPARTMENT SERVICES [9]

Includes those emergency Department facility, physician, and ancillary services that are rendered during an emergency visit. If the Member requires inpatient hospital admission the Member will be responsible for the applicable inpatient hospital admission Copayment or Coinsurance.

	In-Network Coverage	*Out-of-Network Coverage*
Emergency Department Services **A referral is <u>not</u> required.** **Pre-Authorization is <u>not</u> required.**	After Deductible covered at 70%[8] Benefit reduction to 50%[8] for non-emergency use of facilities.	Same as In-Network Benefit Benefit reduction to 50%[8] for non-emergency use of facilities.

URGENT CARE CENTER SERVICES [9]

	In-Network Coverage	*Out-of-Network Coverage*
Urgent Care Center Services **A referral is <u>not</u> required.** **Pre-Authorization is <u>not</u> required.** Includes urgent care center services, primary care and specialist physician services, and other ancillary services received at an Urgent Care center. If you are transferred to an emergency room from an urgent care center, you will be responsible for any applicable emergency room Copayment or Coinsurance.	$30 Copayment	After Deductible covered at 50%[AC] (for non-emergency services only)

MENTAL HEALTH CARE AND SUBSTANCE ABUSE SERVICES

Includes inpatient and outpatient services for the treatment of mental health and substance abuse, and biologically based mental illnesses.

	In-Network Coverage	*Out-of-Network Coverage*
Inpatient Services **Pre-Authorization is required.** [5]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
Outpatient Services **Pre-Authorization is required for outpatient psychological testing.** [5]	$30 Copayment per outpatient visit.	After Deductible covered at 50%[AC]
Employee Assistance Program (EAP)	$0 Copayment for up to three Employee Assistance Program (EAP) visits per presenting issue according to treatment protocols.	Covered In-network only from Participating EAP providers.

OTHER COVERED SERVICES		
	In-Network Coverage	***Out-of-Network Coverage***
Artificial Limb Services [5,6] **Pre-Authorization is required.** For adults 18 and over, artificial limbs, including repair and replacement, will be covered up to a $10,000 lifetime maximum. For children under age 18, artificial limbs, including repair and replacement, will be covered up to $10,000 per occurrence for a maximum of two occurrences.[6]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
Chiropractic Care [6] **Administered by American Specialty Health Networks (ASHN).** Coverage is limited to a combined maximum benefit with in and out of network benefits of $500 per Member, per calendar year. Chiropractic appliances are covered up to $50 maximum benefit per Member per calendar year when medically necessary. For providers not in the ASHN network the Member will be responsible for payment of all charges in excess of ASHN's allowable charge in addition to any coinsurance amount listed at left. Allowable charge is the lesser of the provider's actual charge or ASHN's in-network fee schedule for the same services.	Covered at 70% of ASHN fee schedule	Covered at 60% of ASHN fee schedule

Diabetic Supplies and Equipment Includes FDA-approved equipment and supplies for the treatment of diabetes and in-person outpatient self-management training and education including medical nutrition therapy. Note: Insulin, syringes, and needles are covered under the Plan's Prescription Drug Benefit for the applicable Copayment per 31-day supply.	After Deductible covered at 70%[8] for blood glucose monitoring equipment and supplies including home glucose monitors, lancets, blood glucose test strips, and insulin pump infusion sets. After Deductible covered at 70%[8] for insulin pumps. After Deductible covered at 70%[8] for outpatient self-management training and education, including medical nutritional therapy.	After Deductible covered at 50%[AC]
Durable Medical Equipment (DME) and Supplies **Orthopedic Devices and Prosthetic Appliances** **Pre-Authorization is required for single items over $750.**[5] **Pre-Authorization is required for all rental items.**[5] **Pre-Authorization is required for all repair and replacement.**[5] Covered Services include durable medical equipment, orthopedic devices, prosthetic appliances, colostomy, iliostomy, and tracheostomy supplies, and suction and urinary catheters, and repair and replacement. Coverage is limited to $3,000 combined in-network and out-of-network per member per calendar year.[6]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
Early Intervention Services. **Pre-Authorization is required.**[5] Covered for Dependents from birth to age three who are certified as eligible by the Department of Mental Health, Mental Retardation and Substance Abuse Services. Covered Services include: Medically Necessary speech and language therapy, occupational therapy, physical therapy and assistive technology services and devices . **Coverage is limited to $5,000 per Member per calendar year.**	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service.	Members are responsible for any applicable Copayment, Coinsurance, or Deductible depending on the type and place of service
Home Health Care Skilled Services [5,6] **Pre-Authorization required**[5] A member must be homebound and unable to receive services outside the home to receive care. An outpatient therapy Copayment or Coinsurance will apply to physical, occupational, and speech therapy received in the home.	After Deductible covered at 70%[8] Maximum combined benefit with Out-of-Network benefit of 100 visits per calendar year.	After Deductible covered at 50%[AC] Maximum combined benefit with In-Network benefits of 100 visits per calendar year.

Hospice Care **Pre-Authorization is required.**[5]	After Deductible covered at 70%[8]	After Deductible covered at 50%[AC]
Preventive Vision Services **Administered by EyeMed Vision Services.** Covered for one examination every 24 months performed by a Participating EyeMed Provider	$15 Copayment per eye examination once every 24 months. Contact lens examinations require the eye examination Copayment plus the difference between the contact lens examination cost and the eyeglass examination cost	$30 reimbursement for exam only
Reduction Mammoplasty Coinsurance will apply to all applicable services associated with Reduction Mammoplasty including but not limited to physician, facility, surgical, and/or diagnostic services. This does not include Reduction Mammoplasty procedures associated with reconstructive breast surgery following mastectomy.	After Deductible covered at 50%[8]	After Deductible covered at 50%[AC]

NOTES

The Covered Services herein are subject to the terms and conditions set forth in the Certificate of Insurance form number OHIC.PPO.COI.7.08

1. Maximum benefits payable under the Plan.
2. Deductible means the dollar amount of covered medical expenses for which a Member is responsible to pay before benefits are payable under the Plan. A Plan may have a separate deductible for in network services and for out of network services. Any such amount will not be reimbursed under the Plan. Any part of the calendar year deductible that is satisfied in the last three months of a calendar year can be carried forward to the next calendar year. Amounts which a member is required to pay for outpatient prescription drugs, preventive vision, vision materials, will not be applied to any Deductible amount in the Plan. The Deductible does not apply to Physician office visits and the Member is required to pay applicable office visit Copayment only. Amounts applied to an in-network deductible will apply toward the Plan's in-network out of pocket maximum amount. Amounts applied to an out-of-network deductible will apply toward the Plan's out of network out of pocket maximum amount.
3. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered In-Network Services. The In-Network Deductible will apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less except vaccines, or amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures do not count toward the In-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The Out-Of-Network Deductible does not apply toward the In-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for Out-Of-Network Covered Services do not count toward the In-Network Out-Of-Pocket Maximum.
4. The total amount a Subscriber and/or Dependents will pay during a calendar year for covered Out-of-Network Services. The Out-Of-Network Deductible will apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for non-biologically based outpatient mental health care, vision care, outpatient prescription drugs, any ridered benefits except morbid obesity, any covered medical expenses paid at a rate of 50% or less except vaccines, amounts which a covered person is required to pay for failure to comply with the Plan's Pre-Authorization and Referral procedures, or amounts which are in excess of the Plan's Allowable Charge do not count toward the Out-Of-Network Out-Of-Pocket Maximum and must continue to be paid after the maximum has been met. The In-Network Deductible does not apply toward the Out-Of-Network Out-Of-Pocket Maximum. Copayments or Coinsurances for In-Network Covered Services do not count toward the Out-Of-Network Out-Of-Pocket Maximum.
5. Pre-Authorization is required. A Member's benefits under the policy will be reduced, after any deductible amount, if he/she does not comply with the Plan's referral and pre-authorization procedures. Details concerning the Plan's referral and pre-authorization procedures, including possible benefit reductions for not following the requirements, are provided under Section III in the Certificate of Insurance. If a Member does not properly follow the Plan's Pre-Authorization procedures and ensure that the provider/physician has obtained Pre-Authorization when it is required, and the Plan determines through Retrospective Review that the Covered Service was Medically Necessary, the Plan will apply a $500 fee which will be offset against any benefit owed by the Plan. The penalty fee with not count toward any Plan Deductible or maximum out of pocket amounts.
6. Maximum amounts are combined maximums of both In-Network and Out-Of Network Covered Services unless otherwise indicated. Amounts in excess of a benefit dollar limit and/or visit limit as stated in the Schedule of Benefits or added by a Plan rider are excluded from Coverage.
7. N/A.
8. Benefits are payable at the percent specified of the Plan's fee schedule.
9. All Emergency, Urgent Care, Ambulance and Emergency Mental Health Services may be subject to Retrospective Review to determine the Plan's responsibility for payment. If the Plan determines that the condition treated was not an emergency, the benefit will be reduced as specified on the Schedule of Benefits. Members who receive Emergency services from Non-Plan Providers may be responsible for charges in excess of what would have been paid had the emergency care been received from Plan Providers. In no event will the Plan be responsible for payment for services from Non-Plan Providers where the service would not have been covered had the member received care from a Plan Provider.
10. Coverage for obstetrical services as an inpatient in a general hospital or obstetrical services by a physician shall provide such benefits with durational limits, deductibles, coinsurance factors, and copayments that are no less favorable than for physical illness generally.

AC Benefits for Covered Services performed by any provider who is not a Plan Provider will be based on either a negotiated or agreed upon reimbursement or on an allowable charge which is the lesser of the provider's actual charge or the Plan's in-network fee schedule for the same service performed by the same type of provider. The Member will be responsible for payment of all charges in excess of the Plan's allowable charge in addition to any copayment and coinsurance amounts he/she is required to pay. Charges from non-Plan providers will generally exceed the Plan's allowable charge.

MEMORANDUM

THE TOWN OF CHINCOTEAGUE

To: Mayor & Council

From: Robert G. Ritter Jr., Town Manager

Date: June 16, 2009

Subject: Fiscal Year 2010 Budget

The budget for FY 2010 has been properly advertised and the mandatory public hearing was conducted at the June 1, 2009, Council meeting.

Council is respectfully requested to consider making a motion to **"adopt the budget for the fiscal year 2010 including the real estate tax rate of $0.06/100 of assessed value, tangible property tax rate of $0.85/100, tangible property tax relief of $0.63/100, excise tax (meals) at 4 %, excise tax (transient occupancy) at 3%, including the General Government, Harbor, & Water fee schedules and appropriate the funds for disbursement."**

SUMMARY SHEET FOR THE FISCAL YEAR 2010 BUDGET

	Fiscal Year 2010
General Government Revenue	**$ 4,204,366**
Main Street Revenue	**$ 346,920**
Harbor Revenue	**$ 273,973**
Trolley Revenue	**$ 75,400**
Water Department Revenue	**$ 936,670**
Total FY 2010 Budget Revenue	**$5,837,329**

General Government Expenditures	
• General Gov. Administration	$ 1,555,396
• Public Works Administration	$ 610,599
• Mosquito Control Department	$ 150,894
• Facilities Department	$ 341,021
• Roads Department	$ 527,998
• Police Department	$ 741,398
• 911 Dispatch Department	$ 277,060
Total Gen Gov. Expenditures	**$ 4,204,366**
Main Street Expenditures	**$ 346,920**
Harbor Expenditures	**$ 273,973**
Trolley Expenditures	**$ 75,400**
Water Department Expenditures	**$ 936,670**
Total FY 2010 Budget Expenditures	**$5,837,329**

FISCAL YEAR 2010 BUDGET

FUND 10 - GENERAL FUND

Account No	Account Desc	Total Budget
	REVENUES	
10.4001.0100	REAL ESTATE TAX LEVY	599,278.00
10.4001.0125	TANGIBLE PROP. TAX LEVY	185,000.00
10.4001.0130	DEL.TAX,INTEREST,PENALTY	27,000.00
10.4001.0500	MEALS TAX	445,000.00
10.4001.0600	BANK FRANCHISE TAX	42,000.00
10.4010.0100	SALES TAX	110,000.00
10.4010.0200	BUSINESS LICENSE	105,000.00
10.4010.0300	MOTOR VEHICLE LICENSE	79,000.00
10.4010.0500	UTILITIES TAX	126,765.00
10.4010.0600	TRANSIENT OCCUPANCY TAX	560,000.00
10.4015.0100	FINES	40,000.00
10.4020.0100	INTEREST ON SAVINGS	75,000.00
10.4041.0150	CEMETERY CLEANUP DONATION	1,000.00
10.4041.0200	USER FEES	25,000.00
10.4041.0500	BUILDING PERMITS	40,000.00
10.4041.0600	ZONING ADVERTISEMENTS	2,000.00
10.4045.0100	GRANTS/LITTER	2,655.00
10.4049.0100	SALE OF CAPITAL ASSETS	500.00
10.4051.0200	OPTIMUM CHOICE/RET.SPOUSE	20,796.00
10.4051.0300	VA FIRE PROGRAMS	10,000.00
10.4061.0100	REVENUE SHARING - USFWS	4,200.00
10.4061.0105	HARBOR ADMINISTRATION	7,000.00
10.4061.0106	RENTAL INCOME - TROLLEY	12,000.00
10.4061.0107	TOWER RENT	4,800.00
10.4071.0100	COMMUNICATIONS TAX	243,200.00
10.4071.0200	PERSONAL PROP TAX RELIEF ACT	150,250.00
10.4071.0300	MOBILE HOME SALES TAX	6,200.00
10.4091.0100	OVERAGE/SHORTAGE	0.00
10.4101.0200	RECOVERED COST FROM WATER	123,720.00
10.4201.0100	PUBLIC WORKS MISC. REV	10,000.00
10.4303.0100	MISCELLANEOUS INCOME	15,000.00
10.4303.0300	TIPPING FEE REFUND - CTY.	49,333.00
10.4303.0400	SOLID WASTE COLLECTION FEE	193,665.00
10.4401.0100	LAW ENFORCEMENT FUNDS	125,014.00
10.4401.0125	POLICE MISCELLANEOUS	1,000.00
10.4401.0150	POLICE DONATIONS	20,000.00
10.4401.0160	POLICE GRANTS	5,000.00
10.4401.0161	COPS GRANT	40,350.00
10.4401.0200	911 DISPATCH REVENUE	15,000.00
10.4401.0300	911 LOCAL TAX	0.00
10.4401.0450	TRF FROM 911 EQUIPMENT RESERVES	0.00
10.4501.0100	VDOT MAINTENANCE FUNDS	527,998.00

10.4501.0101	ROAD PERMIT FEES	800.00
10.4545.0140	VA COMM FOR ARTS-GRANT	5,000.00
10.4545.0150	SRTS GRANT	17,040.00
10.4701.0600	TRF. FROM DRAINAGE SAVING	0.00
10.4701.1000	TRF.FROM GEN.FUND SAVINGS	63,000.00
10.4701.1100	TRF FROM MC SAVINGS	68,802.00
		4,204,366.00

FUND 10 - GENERAL FUND

Account No	**Account Desc**	**Total Budget**
	EXPENDITURES	
DEPARTMENT - GENERAL GOVERNMENT		
10.5010.0101	SALARIES - MAYOR	4,800.00
10.5010.0102	SALARIES - COUNCIL	23,040.00
10.5010.1001	SALARIES - TOWN OFFICE	360,681.00
10.5010.1002	SALARIES - EMERG MED STAFF	219,778.00
10.5010.1003	OVERTIME - TOWN OFFICE & EMS	36,000.00
10.5010.2001	SOCIAL SECURITY	49,290.00
10.5010.2101	HOSPITALIZATION FRINGE	60,764.00
10.5010.2201	RETIREMENT	57,444.00
10.5010.2202	VRS LIFE INSURANCE FRINGE	2,513.00
10.5020.2102	BLOOD BANK	100.00
10.5020.2103	UNEMPLOYMENT/TOWN	5,000.00
10.5030.3100	BANK CHARGES	750.00
10.5030.3101	BUILDING ADMIN EXPENSE	100.00
10.5030.3102	CLEANING	9,000.00
10.5030.3103	PLANNING COMMISSION	40.00
10.5030.3104	BOARD OF ZONING APPEALS	40.00
10.5030.3105	BUILDING PERMIT SURCHARGE	1,175.00
10.5030.3106	BOARD OF BLDG CODE APPEAL	25.00
10.5030.3107	EMS CLOTHING ALLOWANCE	2,200.00
10.5030.3108	EMS CELL ALLOWANCE	1,600.00
10.5030.3401	INSURANCE	95,000.00
10.5030.3501	AUDITING	23,800.00
10.5030.3601	DONATIONS	6,600.00
10.5030.3602	FIRE DEPARTMENT DONATION	19,650.00
10.5030.3701	TRF.TO CIVIC CENTER (TO)	95,200.00
10.5030.3705	TOURISM-5%CHAMBER 5%CIVIC	44,500.00
10.5030.4030	ANPDC MEMBERSHIP	7,000.00
10.5030.4301	SCHOLARSHIP	1,000.00
10.5030.4401	OFFICE SUP./PUBLICATIONS	10,000.00
10.5030.4402	OFF.EQUIP/SOFTWARE MAINT.	20,000.00
10.5030.4403	POSTAGE	10,000.00
10.5030.4404	TAX BILLS & CONVERSION	750.00
10.5030.4501	MOTOR VEHICLE LICENSE	2,100.00
10.5030.4701	GASOLINE/DIESAL	0.00
10.5030.4801	TRAVEL & TRAINING	3,800.00
10.5030.4901	MAYORS EXPENSE	300.00
10.5030.4902	COUNCILS EXPENSE	500.00
10.5030.4903	TOWN MANAGERS EXPENSE	250.00

10.5030.5101	ATTORNEY/LEG.CONSULTANTS	29,000.00
10.5030.5201	DRUG/ALCOHOL TESTING	2,000.00
10.5030.5501	CHRISTMAS DINNER	4,000.00
10.5030.6101	DUES	3,000.00
10.5030.6102	VML CONFERENCE	1,000.00
10.5030.7101	ADVERTISING & WEBSITE	11,000.00
10.5030.7301	BUILDING MAINTENANCE	5,000.00
10.5030.7401	ELECTRICITY	14,500.00
10.5030.7402	HEATING OIL	3,500.00
10.5030.7601	VA FIRE PROG/CVFC	10,000.00
10.5030.7602	EOC OPERATIONS/TRAINING	1,500.00
10.5030.7701	SPECIAL PROJECTS	7,000.00
10.5030.7702	PONY PENNING EXPENSE	5,000.00
10.5030.7703	DEER DE-POP PROGRAM	8,500.00
10.5030.8001	LEONARD ASSISTANCE FUND	0.00
10.5030.8202	TELEPHONE BILLS	14,000.00
10.5030.8401	OPTIMUM CHOICE - RETIREES	46,000.00
10.5030.8402	INSUR-RET SPOUSES & OTHER	20,796.00
10.5030.8501	MISCELLANEOUS	5,000.00
10.5030.8600	CEMETERY CLEANUP	1,500.00
10.5030.8700	VA COMM. FOR THE ARTS	10,000.00
10.5030.8800	TRANSFER TO MAIN ST. PROJ	63,000.00
10.5030.8900	TRANSFER TO TROLLEY FUND	20,000.00
10.5030.8910	TRANSFER TO RESERVES	0.00
10.5030.8912	VOLSAP FOR VOLUNTEER FIREFIGHTERS	2,640.00
10.5090.9704	PROPERTY ACQUISTION RESER	0.00
10.5090.9709	OFFICE EQUIP	6,000.00
10.5090.9710	SERVER BACKUP	2,714.00
10.5090.9740	BOND-SCHOOL BD PROPERTY	67,168.00
10.5090.9741	INTEREST ON BOND	15,789.00
10.5090.9750	PLANNING CONSULTANTS	1,000.00
	TOTAL GENERAL GOVERNMENT	**1,555,397.00**

Account No	**Account Desc**	**Total Budget**
DEPARTMENT - PUBLIC WORKS ADMINISTRATION		
10.6010.1001	SALARIES - PUBLIC WORKS ADMIN	81,763.00
10.6010.1003	OVERTIME - PUBLIC WORKS ADMIN	500.00
10.6010.2001	SOCIAL SECURITY	6,293.00
10.6010.2101	HOSPITALIZATION FRINGE	13,833.00
10.6010.2201	RETIREMENT	7,777.00
10.6010.2202	VRS LIFE INSURANCE FRINGE	339.00
10.6030.4401	OFFICE SUPPLIES & EQUIP.	500.00
10.6030.4501	STREET MAINTENANCE	1,000.00
10.6030.4502	STREET SIGNS/ 911	2,000.00
10.6030.4503	STREET LIGHTS	59,000.00
10.6030.4701	GASOLINE/DIESEL	22,875.00
10.6030.4703	OIL/GREASE	1,500.00
10.6030.4704	TOOLS/SHOP	2,000.00
10.6030.4801	TRAVEL & TRAINING	1,250.00
10.6030.5202	CLOTHING/UNIFORMS	1,175.00
10.6030.7301	BLDG. MAINTENANCE	1,500.00

10.6030.7302	EQUIPMENT REPAIRS	10,000.00
10.6030.7303	SAFETY	250.00
10.6030.7304	VEHICLE P/M'S	500.00
10.6030.7305	TIRES	2,000.00
10.6030.7306	GARAGE SUPPLIES	2,000.00
10.6030.7307	VEHICLE REPAIRS	6,000.00
10.6030.7401	ELECTRICITY	7,500.00
10.6030.7402	LP GAS	2,000.00
10.6030.7501	TIPPING FEES	1,200.00
10.6030.7502	SANITATION CONTRACT	374,344.00
10.6030.8501	MISCELLANEOUS	1,500.00
10.6030.9531	SEWAGE TREATMENT STUDY	0.00
	TOTAL PUBLIC WORKS ADMINISTRATION	**610,599.00**

Account No	**Account Desc**	**Total Budget**
DEPARTMENT - MOSQUITO CONTROL		
10.6110.1001	SALARIES - MOSQUITO CONTROL	41,338.00
10.6110.1003	OVERTIME - MOSQUITO CONTROL	1,000.00
10.6110.2001	SOCIAL SECURITY	3,239.00
10.6110.2101	HOSPITALIZATION	277.00
10.6110.2201	RETIREMENT	310.00
10.6110.2202	LIFE INSURANCE	15.00
10.6130.3401	INSURANCE	8,100.00
10.6130.4701	GASOLINE	2,875.00
10.6130.4704	TOOLS & SMALL EQUIPMENT	1,000.00
10.6130.4705	CHEMICALS	31,100.00
10.6130.4706	CONTRACT SPRAYING	23,000.00
10.6130.4801	TRAVEL/TRAINING/CONFERENCE	300.00
10.6130.5202	UNIFORMS	500.00
10.6130.6101	SUNDRY	200.00
10.6130.7302	EQUIPMENT REPAIRS/MAINTENANCE	1,000.00
10.6130.7303	SAFETY EQUIPMENT	400.00
10.6130.7304	VEHICLE MAINTENANCE	1,000.00
10.6190.9124	EQUIPMENT	12,990.00
10.6190.9125	DRAINAGE	22,250.00
	TOTAL MOSQUITO CONTROL	**150,894.00**

Account No	**Account Desc**	**Total Budget**
DEPARTMENT - FACILITIES		
10.6310.1001	SALARIES - FACILITIES	218,721.00
10.6310.1003	OVERTIME - FACILITIES	3,000.00
10.6310.2001	SOCIAL SECURITY	16,962.00
10.6310.2101	HOSPITALIZATION FRINGE	36,589.00
10.6310.2201	RETIREMENT	19,984.00
10.6310.2202	VRS LIFE INSURANCE FRINGE	935.00
10.6330.4100	SEASONAL DECO & BANNERS	2,000.00
10.6330.4101	STREET MAINTENANCE	0.00
10.6330.4201	SIDEWALKS	0.00
10.6330.4202	STREET SIGNS/911	0.00
10.6330.4704	TOOLS	750.00
10.6330.4708	MOWERS/TRIMMERS	0.00

10.6330.5202	UNIFORMS	5,179.00
10.6330.6260	PUBLIC RESTROOM SUPPLIES	2,000.00
10.6330.6301	WEED CUTTING/SPRAYING	0.00
10.6330.7302	EQUIPMENT REPAIRS	0.00
10.6330.7401	ELECTRICITY	3,500.00
10.6330.7450	STREET LIGHTS	0.00
10.6330.8501	SUNDRY	200.00
10.6330.8590	PARKS & REC EXPENSE	3,000.00
10.6330.8600	VANDALISM REPAIRS	2,000.00
10.6330.8700	BOAT RAMP EXPENSE	2,000.00
10.6330.8701	TRANSFER TO BOAT RAMP REPAIRS RESERVES	23,000.00
10.6330.8800	DONALD J LEONARD PARK	200.00
10.6330.8900	ISLAND NATURE TRAIL	1,000.00
10.6390.9105	DRAINAGE	0.00
10.6390.9200	PLAYGROUND EQUIPMENT RESERVE	0.00
10.6390.9660	FOWLING GUT - CHURCH ST.	0.00
10.6390.9846	BASE MAPPING/GIS SYSTEM	0.00
10.6390.9855	CHURCH/PENSION DRG. PROJ	0.00
10.6390.9880	SEWAGE TREATMENT STUDY	0.00
	TOTAL FACILITIES	**341,020.00**

Account No	**Account Desc**	**Total Budget**
DEPARTMENT - ROADS		
10.6510.1001	SALARIES - ROADS	72,855.00
10.6510.1003	OVERTIME - ROADS	2,000.00
10.6510.2001	SOCIAL SECURITY	5,726.00
10.6510.2101	HOSPITALIZATION FRINGE	12,130.00
10.6510.2201	RETIREMENT	7,755.00
10.6510.2202	VRS LIFE INSURANCE FRINGE	367.00
10.6530.4102	SNOW REMOVAL	1,000.00
10.6530.4150	PAVEMENT MAINTENANCE	302,665.00
10.6530.4201	SIDEWALKS	30,000.00
10.6530.4202	SIGNS/TRAFFIC CONTROL	0.00
10.6530.4250	ROADSIDE STRUCTURES	3,000.00
10.6530.4704	TOOLS/SMALL EQUIPMENT	0.00
10.6530.4705	EQUIPMENT EXPENSE	0.00
10.6530.6250	DRAINAGE MAINTENANCE	50,000.00
10.6530.6301	WEED CONTROL	0.00
10.6530.7201	TRAFFIC CONTROL OPERATIONS	1,500.00
10.6530.7202	TRAFFIC CONTROL DEVICES	20,000.00
10.6530.7303	WORK ZONE SAFETY	0.00
10.6530.7450	ELECTRICITY	14,000.00
10.6530.8600	ENGINEERING	5,000.00
	TOTAL ROADS	**527,998.00**

Account No	**Account Desc**	**Total Budget**
DEPARTMENT - POLICE		
10.7010.1001	SALARIES - POLICE OFFICERS	471,678.00
10.7010.1003	OVERTIME - POLICE OFFICERS	8,500.00
10.7010.2001	SOCIAL SECURITY	38,295.00
10.7010.2101	HOSPITALIZATION FRINGE	32,160.00

10.7010.2201	RETIREMENT	48,496.00
10.7010.2202	VRS LIFE INSURANCE FRINGE	2,329.00
10.7030.4701	GASOLINE	18,000.00
10.7030.4801	TRAVEL & TRAINING	8,000.00
10.7030.5201	UNIFORM ALLOW OFFICERS	6,000.00
10.7030.5202	UNIFORMS (TOWN)	1,500.00
10.7030.6102	POLICE CONFERENCE	400.00
10.7030.7201	PHOTOGRAPHY	300.00
10.7030.7300	OFFIC SUPP/EQUIP MAINT	9,000.00
10.7030.7302	EQUIP. REPAIRS & SUPPLIES	3,500.00
10.7030.7304	VEHICLE MAINTENANCE	5,000.00
10.7030.7901	DRUG ENFORCEMENT	5,000.00
10.7030.7903	ACADEMY DUES	3,800.00
10.7030.7904	BICYCLE PATROL	200.00
10.7030.7905	COMMUNITY/YOUTH PROGRAMS	20,000.00
10.7030.7906	GRANT FUNDED EXPENDITURES	5,000.00
10.7030.7907	AMMUNITION	1,400.00
10.7030.7908	POLICE DRUG DOG	3,500.00
10.7030.7908	CELL PHONE ALLOWANCE	3,600.00
10.7030.8501	SUNDRY	1,200.00
10.7090.9650	PATROL VEHICLE	27,500.00
10.7090.9675	SURVEILLANCE EQUIPMENT	0.00
10.7090.9685	SRTS PROGRAM PROJECTS	17,040.00
	TOTAL POLICE DEPARTMENT	**741,398.00**

Account No	**Account Desc**	**Total Budget**
DEPARTMENT - EMERGENCY DISPATCH		
10.7510.1001	SALARIES - DISPATCHERS	189,488.00
10.7510.1003	OVERTIME - DISPATCHERS	2,000.00
10.7510.2001	SOCIAL SECURITY	14,493.00
10.7510.2101	HOSPITALIZATION FRINGE	22,687.00
10.7510.2201	RETIREMENT	10,205.00
10.7510.2202	VRS LIFE INSURANCE FRINGE	487.00
10.7530.4801	TRAVEL & TRAINING-DISP.	2,500.00
10.7530.5201	UNIFORM ALLOW DISP	1,400.00
10.7530.5202	UNIFORM (TOWN FOR DISP)	1,500.00
10.7530.7300	OFF. SUPPLIES/EQUIP. MAIN	19,000.00
10.7530.8202	E911 LINE FEES	7,000.00
10.7530.8203	911 ADDRESSING	1,100.00
10.7530.8501	SUNDRY	200.00
10.7590.9270	911 EQUIP. RESERVE FUND	5,000.00
	TOTAL EMERGENCY DISPATCH	**277,060.00**

	TOTAL EXPENDITURES FUND 10 - GENERAL FUND	**4,204,366.00**

FUND 20 - MAIN STREET FUND

Account No	**Account Desc**	**Total Budget**
	REVENUES	
20.4501.0100	PROGRAM INCOME	3,000.00
20.4501.0115	TEA-21 GRANT MAIN ST	277,000.00

20.4501.0200	LOAN REPAYMENT	3,920.00
20.4501.8900	TRANSFER FROM GEN. FUND	63,000.00
	TOTAL REVENUES FUND 20 - MAIN STREET	**346,920.00**

FUND 20 - MAIN STREET FUND

Account No	Account Desc	Total Budget
	EXPENDITURES	
20.2030.7101	MAINTENANCE	1,000.00
20.2030.7401	ELECTRICITY	2,000.00
20.2030.7601	TRF. TO LOAN POOL	3,920.00
20.2090.9711	MAIN STREET PROJECT	340,000.00
	TOTAL EXPENDITURES FUND 20 - MAIN STREET	**346,920.00**

FUND 30 - HARBOR FUND

Account No	Account Desc	Total Budget
	REVENUES	
30.4031.0100	INTEREST ON HARBOR SAVINGS	2,500.00
30.4031.1000	HARBOR RENT	44,120.00
30.4031.1001	RENT NEW SLIPS (RESTROOM)	10,667.00
30.4031.1002	SUBLEASES	17,560.00
30.4031.1003	DRY/WINTER STORAGE	750.00
30.4031.1004	LOADING DOCK	2,520.00
30.4031.1050	VA PORT AUTHORITY GRANT	146,890.00
30.4031.1060	HARBOR MISC	0.00
30.4910.8800	TRF. FROM GENERAL FUND	0.00
30.4910.8900	TRF.FROM LT REPLACEMENT	48,966.00
	TOTAL HARBOR REVENUES	**273,973.00**

FUND 30 - HARBOR FUND

Account No	Account Desc	Total Budget
	EXPENDITURES	
30.8010.1001	SALARIES - HARBOR MASTER	22,459.00
30.8010.1003	OVERTIME - HARBOR MASTER	200.00
30.8010.2001	SOCIAL SECURITY	1,718.00
30.8010.2101	HOSPITALIZATION	0.00
30.8010.2201	RETIREMENT	2,327.00
30.8010.2202	VRS LIFE INSURANCE FRINGE	105.00
30.8030.3100	ADMIN. EXPENSE/TOWN	7,000.00
30.8030.7300	OPERATIONS, MAINT., ETC.	15,500.00
30.8030.7305	DRIVEWAY STONES	15,700.00
30.8030.7310	SIGNS	1,000.00
30.8030.7315	MOWER AND TRIMMER	1,898.00
30.8030.8501	SUNDRY	4,200.00
30.8090.9124	LONG TERM REPLACEMENT RES	0.00
30.8090.9126	CMH REPLACEMENT PROJECT	195,866.00
30.8090.9127	SECURITY SYSTEM	6,000.00
	TOTAL EXPENDITURES FUND 30 - HARBOR	**273,973.00**

FUND 70 - TROLLEY FUND

Account No	Account Desc	Total Budget
	REVENUES	
70.4501.0100	TROLLEY GRANTS	47,900.00
70.4501.0110	PROGRAM INCOME	7,500.00
70.4501.0200	RTAP REIMBURSEMENTS	0.00
70.4501.0300	MISCELLANEOUS NON-PROGRAM INCOME	0.00
70.4501.8900	TRANSFER FROM GEN. FUND	20,000.00
	TOTAL REVENUES FUND 70 - TROLLEY	**75,400.00**

FUND 70 - TROLLEY FUND

Account No	Account Desc	Total Budget
	EXPENDITURES	
70.3010.0100	SALARIES - TROLLEY	30,000.00
70.3010.1003	OVERTIME	0.00
70.3010.2001	SOCIAL SECURITY	2,400.00
70.3030.3401	INSURANCE & BONDING	4,000.00
70.3030.4402	SIGNS/PRINTING/ADVERTISING	3,500.00
70.3030.4701	GASOLINE/DIESAL	8,000.00
70.3030.5201	DRUG/ALCOHOL TESTING	1,000.00
70.3030.7302	EQUIPMENT REPAIRS/MAINT	13,000.00
70.3030.8501	OTHER EXPENSES	1,500.00
70.3030.8505	RENT EXPENSE TO FUND 10	12,000.00
70.3090.9100	CAPITAL EXPENDITURES	0.00
	TOTAL EXPENDITURES FUND 70 - TROLLEY	**75,400.00**

FUND 80 - WATER FUND

Account No	Account Desc	Total Budget
	REVENUES	
80.4101.0100	WATER RENT	875,000.00
80.4101.2200	WATER ADJUSTMENTS	-500.00
80.4131.0100	WATERLINE EXTENSIONS	10,000.00
80.4131.0200	SERVICE CONNECTIONS	16,939.00
80.4131.0300	INTEREST ON WATER SAVINGS	360.00
80.4131.0400	MISCELLANEOUS	500.00
80.4131.0500	AVAILABILITY FEES	34,371.00
80.4701.0100	TRANSFER FR WATER RESERVE	0.00
	TOTAL REVENUES FUND 80 - WATER	**936,670.00**

FUND 80 - WATER FUND

Account No	Account Desc	Total Budget
	EXPENDITURES	
80.6210.1001	SALARIES - WATER DEPT	200,025.00
80.6210.1003	OVERTIME - WATER DEPT	3,000.00
80.6210.1004	SALARIES - PUMP DUTY	12,363.00
80.6210.2001	SOCIAL SECURITY	16,477.00
80.6210.2101	HOSPITALIZATION FRINGE	30,100.00
80.6210.2201	RETIREMENT	19,227.00
80.6210.2202	VRS LIFE INSURANCE FRINGE	908.00
80.6230.3100	BANK CHARGES	0.00
80.6230.4401	OFFICE SUPP/EQUIP MAINT	2,500.00

80.6230.4403	POSTAGE	2,825.00
80.6230.4701	GASOLINE/DIESAL	3,960.00
80.6230.4704	TOOLS	750.00
80.6230.4705	CHEMICALS	6,600.00
80.6230.4801	TRAVEL & TRAINING	2,500.00
80.6230.5202	UNIFORMS	1,300.00
80.6230.6101	DUES/LICENSES	600.00
80.6230.7301	BUILDING MAINT/REHAB	2,000.00
80.6230.7302	EQUIPMENT REPAIRS	0.00
80.6230.7303	SAFETY	500.00
80.6230.7304	VEHICLE MAINTENANCE	500.00
80.6230.7400	RAW WATER PURCHASE (NASA)	500.00
80.6230.7401	ELECTRICITY	41,240.00
80.6230.7402	LP GAS	500.00
80.6230.8101	DISTRIBUTION & REPAIRS	20,000.00
80.6230.8103	SUPPLY REPAIRS	15,000.00
80.6230.8202	PAGER/WELL MONITORING	500.00
80.6230.8204	MISS UTILITY	500.00
80.6230.8501	SUNDRY	200.00
80.6230.8601	REIMBURSEMENT TO FUND 10	63,750.00
80.6230.8602	REIMBURSEMENT TO FUND10 (4 years, @ $5K/M)	60,000.00
80.6230.8750	REGULATION COMPLIANCE	3,000.00
80.6230.8770	STATE GROUNDWATER PERMITS	6,300.00
80.6230.8800	EQUIPMENT EXPENSE TO FUND 10	1,000.00
80.6230.9100	ENGINEERING	500.00
80.6290.9101	WATER MAIN EXTENSIONS	10,000.00
80.6290.9504	INTEREST WT BOND SUPPLY MAIN STREET	32,007.00
80.6290.9505	WATER BOND-SUPPLY MAIN ST	93,865.00
80.6290.9506	WATER BONDS	158,540.00
80.6290.9507	INTEREST ON WATER BONDS	83,133.00
80.6290.9601	GENERATOR FOR WATER WELLS	20,000.00
80.6290.9603	PENSION WATERLINE REPLACEMENT	10,000.00
80.6290.9846	BASE MAPPING/GIS SYSTEM	0.00
80.6290.9850	6 WHEEL HEAVY DUTY TRUCK	10,000.00
80.6290.9860	S.C.A.D.A.	0.00
	TOTAL EXPENDITURES FUND 80 - WATER	**936,670.00**

GENERAL GOVERNMENT FEES

Building and Zoning Permit Fees

Category	CURRENT FY "10"	CURRENT FY "09"
Res. New Construction: per sq ft	$0.18	$0.18
Res. New Const.: minimum fee	$80.00	$80.00
Res. Remodeling & Alterations: per sq ft	$0.13	$0.13
Res. Remodeling & Alterations: minimum fee	$60.00	$60.00
Comm. New Construction: per sq ft	$0.23	$0.23
[plus $5 per plumbing fixture (Chinco)]		
Comm. New Constr.: minimum fee	$110.00	$110.00
Comm. Remodeling & Alterations: per sq ft	$0.18	$0.18
Comm. Remodeling & Alterations: minimum fee	$90.00	$90.00
Mobile Homes: per sq ft	$0.18	$0.18
Demolition of Structure: Residential	$30.00	$30.00
Demolition of Structure: Commercial	$30.00	$30.00
Removal/Installation fule tanks:		
1000-3000 gallon capacity	$115.00	$115.00
Each additional 1000 gallon capacity	$25.00	$25.00
Installation of radio or communication tower:		
Up to 100 feet	$115.00	$115.00
Each additional 100 feet	$45.00	$45.00
Each Additional Attachement		
Piers or Bulkheads:		
Up to 300 linear feet	$90.00	$90.00
Each additional 100 linear feet	$11.00	$11.00
New Docks: per sq ft	$0.18	$0.18
Boat ramps & groins	$115.00	$115.00
Swimming Pools:		
Above-ground	$60.00	$60.00
In-ground	$80.00	$80.00
Commercial	$80.00	$80.00
Re-roofing (adding 1 layer to existing)	$45.00	$45.00
Installing New Sheathing-Residential while re-roofing		
Installing New Sheathing-Commercial while re-roofing		
Re-siding	$45.00	$45.00
Moved Buildings	$80.00	$80.00
For other work not listed:		
Residential	$60.00	$60.00
Commercial	$90.00	$90.00
Certificate of Occupancy (except when issued in		
conjunction w/a building permit):	n/a	n/a
No inspection required	$30.00	$30.00
Inspection required:		
Per sq ft	$0.13	$0.13
Minimum fee	$60.00	$60.00
Appeals to the Board of Appeals	$450.00	$450.00
Administrative Fees:		
Lost permit (reissue)	$30.00	$30.00
Permit amendment (reissue)	$30.00	$30.00
Change of use	$50.00	$50.00
Permit 6-month extension (2 ext. maximum)	$30.00	$30.00
For beginning constr. prior to obtaining BP:		
First offense	$50.00	$50.00
Each offense thereafter	$200.00	$200.00
Re-inspection fee	$40.00	$40.00
State Code Academy Surcharge	1.75%	1.75%
Refunds: (% of amount paid)		
Permit issued, no inspections	75%	75%
Foundation inspection completed	75%	75%
Framing & foundation inspection completed	25%	25%
Subdivision Review Fees (per each submitted plat):		
Up to 10 lots:		
Base fee	$200.00	$200.00
Each lot (in addition to base fee)	$10.00	$10.00
Over 10 lots or required new road construction:		

GENERAL GOVERNMENT FEES

Building and Zoning Permit Fees

Category	CURRENT FY "10"	CURRENT FY "09"
Base fee	$500.00	$500.00
Each lot (in addition to base fee)	$20.00	$20.00
Zoning Fees:		
Zoning inspections	$0.00	$35.00
Special use permit	$450.00	$450.00
Conditional use permit	$1,500.00	$1,500.00
Variance application	$450.00	$450.00
Special use permit & variance application processed & presented at same time	$540.00	$540.00
Appeal decision of Zoning Administrator	$450.00	$450.00
Proposed rezoning change	$730.00	$730.00
Amendment to the zoning ordinance	$330.00	$330.00
Vacating any subdivision plat or any part thereof	$250.00	$250.00
Certification of zoning compliance (includes home occupation)	$30.00	$30.00
Site evaluation (subdivision)	$100.00	$100.00
Travel Trailer Park Fees:		
Up to 25 trailers	$500.00	$500.00
26-49 trailers	$1,000.00	$1,000.00
50 or more trailers	$2,000.00	$2,000.00
Base fee		
Each lot if over 4 lots (plus base fee)		
Sign Permit Fees:		
Less than or equal to **25** square feet	$45.00	$45.00
Each sq ft in excess of **25** sq ft	$1.00	$1.00
Mobile Home Park Fees:		
4-25 mobile homes	$1,000.00	$1,000.00
26-40 mobile homes	$2,000.00	$2,000.00
41 or more mobile homes	$5,000.00	$5,000.00
Base fee		
Each lot if over 4 lots (plus base fee)		
Transcript Fees (per page)	$12.00	$12.00
Document Fees:		
Comprehensive Plan	$20.00	$20.00
Zoning Ordinance	n/a	n/a
Subdivision Ordinance	n/a	n/a
Complete ordinances, incl zoning & subdivision	$35.00	$35.00
Excerpts from Ordinances & Other Town Documents: per page and/or double sided per page	$0.50	$0.50
Maps 36" x 44"	$55.00	$55.00
Contractors List (Class A & B)	$0.00	$0.00
New Address Fee	$25.00	$25.00
New Road Fee (at cost per MSAG)	cost	cost
Elevators/Escalators/Lifts	$60.00	$60.00
Mobile Offices/Pre-manufactured Units	$60.00	$60.00
Tent/Air Support Structures (over 900 sq ft)	$80.00	$80.00
Carport or Garage: per sq ft	$0.18	$0.18
Accessory building/structure (<150 sq ft)	$45.00	$45.00
Deck: per sq ft	$0.18	$0.18
Fence (> 8 linear ft. Total)	$45.00	$45.00
Fireplace	$0.00	$0.00
Foundation	$60.00	$60.00
General Government Taxes and Fees		
Real Estate Tax ($.06/100)	$0.06	$0.06
Tangible Property Tax ($/100)	$0.85	$0.85
Tangible Property Tax Relief (percent)	63%	62%
Excise Tax; Meals (percent)	4%	4%
Excise Tax; Transient Occupancy Tax (percent)	3%	3%
Vehicle Decals (annual)	$27.00	$27.00
Road Sudivision Review Fee	$250.00	$250.00
Side Walk Adminitrative Fee (Percent)	25%	25%
Solid Waste Collection Fee (Residential per week)	$1.00	$1.00
Solid Waste Collection Fee (Commercial/Business per week)	$1.00	$1.00

FISCAL YEAR 2010
Rate Schedule
Curtis Merritt Harbor

(July 1, 2009 – June 30, 2010)

25 ft Slip $390.40
30 ft Slip $441.20
40 ft Slip $664.31
50 ft Slip $966.81
Slip at head of Collector Pier $1061.28

Loading Dock fees are $7.00 per day after 4 hours for commercial vessels and $10.00 a day for recreational vessels with a $25.00 minimum.

Sublease rate for Commercial Vessels: $3.50 per day or any portion of a day.

Sublease rate for recreational vessels: $10.00 per day or any portion of a Day with a $25.00 minimum or $50.00 a Week (7 days) or $200.00 a Month (30 days) any size slip.

Nets or other items left on dockside for storage over 3 days will be charged a $10.00 fee per day.

Boat repair area for Harbor lessee is $10.00 per day after 7 days per season haul out.

For Non Harbor Lessee there will be $10.00 a day charge after the first 8 hours.

Fees or Penalties for leaving the work area not cleaned $50.00 one time penalty per haul out. If payment is not received all Harbor and Town Property privileges will be prohibited.

Trailer parking with Harbormasters permission, short term (less than Two weeks) $5.00 per day. Trailer must have a tag and a user fee sticker.

D.W.MERRITT HARBORMASTER

A minimum rate applies to all accounts after the minimum allowed usage and an additional dollar amount is applied per 1000 gallons. The following table applies to 5/8 and 3/4 residential, commercial and other size water meter connections, subject to a review by council for a 3% increase each year.

Meter Size (inches)	Minimum Bill (Quarter)	Allowed Usage (gallons)	Per 1,000 gallons Over Allowance
5/8 & 3/4	$26 residential $42 commercial	6,000 6,000	$3.99 $4.73
1	$105	15,000	$4.73
1.5	$208	30,000	$4.73
2	$334	48,000	$4.73
3	$665	96,000	$4.73
4*	$1040	150,000	$4.73
6	$2080	300,000	$4.73
8	$3328	480,000	$4.73

*One meter currently in the system is to be charged $5.97 per 1000 gallons over the allowed usage.

Connection Fees

New connections to the water system shall be charged at the rate below plus all additional related costs incurred by the town:

$620 for a 5/8" or 3/4" Meter connecting pipe
$1,126.00 for a 1" connecting pipe
$1,520 for a 2" connecting pipe

Availability Fee Schedule

Meter Size (inches)	Availability Fee
5/8 & 3/4	$3,708
1	$9,270
1.5	$18,540
2	$29,664
3	$59,328
4	$92,700
6	$185,400
8	$296,640

Condominiums are charged an availability fee of $3,819 per living unit but supplied by a master meter with the minimum billing based on the size of the meter.

Billing and other charges

- No service shall be reconnected without payment of all delinquent charges plus a reconnecting charge of $50.00.
- Any person having service disconnected by the Town, shall be charged a fee of $50.00.
- A change of ownership fee of $50.00
- A twenty-five percent administrative fee will be applied to all Water main extensions, by the Town

Water bill adjustments

If, after checking or testing the meter, the reading is found to be correct, the account will be charged $50.00. If the meter or reading is found to be faulty or incorrect, the water bill will be adjusted accordingly.

A RESOLUTION
OF THE
CHINCOTEAGUE TOWN COUNCIL

WHEREAS, William Elliott served Chincoteague well for many years in many capacities; and

WHEREAS, he served faithfully as a member of Town Council and played a vital role in the development of the community; and

WHEREAS, his exemplary conduct and sense of fairness furthered the cause of better understanding and was an influence for good in the growth and progress of our community;

NOW, THEREFORE BE IT RESOLVED, that by the sad and untimely death of Brother William Elliott, the Chincoteague Town Council lost a valuable friend, whose energies and initiative contributed inestimable service to the people of the Town of Chincoteague by his work with the Council; and

BE IT FURTHER RESOLVED, that this Resolution be spread upon the minutes of this meeting and a copy published in the Chincoteague Beacon.

IN TESTIMONY WHEREOF, the Council has caused the corporate seal to be hereunto affixed and the signature of its Mayor, John H. Tarr, this 18th day of June 2009.

John H. Tarr, Mayor

ATTEST:

Robert G. Ritter, Jr., Town Manager

TOWN OF CHINCOTEAGUE, INC.

RESOLUTION

WHEREAS, the Town Council of the Town of Chincoteague, Incorporated desires to submit an application for an allocation of funds of up to $5,000 through the Virginia Department of Transportation Fiscal Year 2010, Revenue Sharing Program; and,

WHEREAS, $5,000 of these funds are requested to fund recycling collection fees along with the Spring and Fall Cleanup Projects;

NOW, THEREFORE, The Town Council of the Town of Chincoteague, Incorporated hereby supports this application for an allocation of up to $5,000 through the Virginia Department of Transportation Revenue Sharing Program.

BE IT FURTHER RESOLVED the Town Council of the Town of Chincoteague, Incorporated hereby grants authority for the Town Manager to execute project administration agreements for any approved revenue sharing projects.

ADOPTED by unanimous vote of the Town Council on June 18, 2009.

_____
John H. Tarr, Mayor

(SEAL)

Attest:

_____
Robert G. Ritter, Jr., Town Manager

6150 COMMUNITY DRIVE, CHINCOTEAGUE ISLAND, VIRGINIA 23336
(757) 336-6519 FAX (757) 336-1965

MEMORANDUM

To: Mayor and Council

From: Robert G. Ritter Jr.

Date: June 16, 2009

Subject: Proposed Curtis Merritt Harbor of Refuge Phase 2 Rehab Project, Change Order

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At the Council meeting of April 6, 2009, BIC Incorporated was awarded the bid on the Curtis Merritt Harbor of Refuge Breakwater project for $384,045. At the Council meeting of June 1, 2009 Council approved the 1st change order for the sum of $13,780, for a new total of the project to be $397,825. Currently the southern sea wall is near completion. Mr. Britton brought to our attention that the portion of the northwest sea wall is 13" lower than the existing bulk heading. The new bulk head will be at the height of the existing dock. The existing dock currently goes under water when we have a little higher tide then normal. The change order will be to build a new dock at the height of the existing bulk head and put in the new bulk head at the height of the rest of the bulkhead around the Harbor. The change order quote for the new deck will be twenty three thousand eight hundred dollars hundred dollars ($23,800) to complete.

Our recommendation would be to:

> "Move to approve the Curtis Merritt Harbor of Refuge Phase 2 Rehabilitation project change order #2 in the amount of twenty three thousand eight hundred dollars ($23, 800) for a new total of the project to be four hundred twenty one thousand six hundred twenty five dollars ($421,625) ."

B.I.C., INC.

PO BOX 248
Stockton, MD 21864
Va. Cont. License Class A
No. 2701-023770A

Phone: 757-854-4122
Fax: 757-854-4327
Classifications:
ELE PLB H/H BLD

PROPOSAL

PROPOSAL SUMMITED TO: Town of Chincoteague
PHONE:
DATE: May 22, 2009
STREET:
JOB NAME: **Curtis Merritt Harbor of Refuge Phase 2**
CITY, STATE & ZIP CODE: Chincoteague, VA 23336
JOB LOCATION: Curtis Merritt Harbor

We Hereby submit specifications and estimates for:

Addendum:
Raise existing 7' x 150' Pier to existing Bulkhead height.
3 x 12' will be placed on top of existing deck and bolted to pile with ¾" bolts outside.
Center 2 – 3 x 12' Stringers will be lag bolted to existing stringers with ½ x 18" lag bolt.
2 x 6 Decking nailed with 20 P. ring shark nails.

WE PROPOSE hereby to furnish material and labor – complete in accordance with above specifications, for the sum of:

Twenty Three Thousand Eight Hundred & 00/100 Dollars($23,800.00).

Payment to be made as follows:

UPON COMPLETION

All material is guaranteed to be as specified. All work to be completed in a workmanlike manner according to standard practices. Any alteration or deviation from above specifications involving extra costs will be executed only upon written orders, and will become an extra charge over and above the estimate. All agreements contingent upon strikes, accidents or delays beyond our control. Owner is to carry fire, tornado and other necessary insurance. Our workers are fully covered by Workman's Compensation Insurance. After execution, this Contract may not be cancelled except by written agreement of the parties. Contractor will comply with all local requirements for building permits, inspections, and zoning.

BIC, INC.
by: _____,
Its authorized agent.

NOTE: This proposal may be withdrawn by us if not accepted Within 30 days

ACCEPTANCE OF PROPOSAL – I (we) also agree to pay a finance charge of two percent (2%) per month (24% APR) on all outstanding amounts not paid within thirty (30) days of the date when due plus a twenty-five percent (25%) attorneys fee and all court cost associated with any past due amounts placed with an attorney for collection.

Signature _____

Signature _____

Date of Acceptance: _____

MEMORANDUM

TO: Mayor Tarr, Council Members & Town Manager

FROM: Major Mills, Assistant Chief of Police

DATE: June 9, 2009

SUBJ: Global Connect Strategic Voice Messaging

Global Connect's voice messaging system allows you to reach thousands of contacts with personalized messages within minutes. The leading provider of web-based voice messaging, Global Connect gives you unsurpassed calling speed and capacity without any capital outlay.

Since the system is web-based, there are no set-up fees, no expensive hardware, or software to buy, no maintenance costs, no minimum usage requirements, no training or service fees, and no recording costs.

With corporate offices in Mays Landing, New Jersey, and eight satellite offices located throughout the country, their service team is available 24 hours a day, 7 days a week, to offer the assistance and the support required.

In an emergency situation, you may need to reach first responders, other staff members, volunteers, and residents, quickly and easily. With unsurpassed speed and capacity, Global Connect allows you to reach thousands of contacts each minute.

Global Connect's real-time reporting feature allows you to see instantly who has received your message, and the system lets you decide how often and how many times you will retry the call. With the Direct-Connect to Dispatch feature, residents can contact the dispatch center with the touch of a button to confirm their condition or request more information. The system also allows residents to leave a detailed message by simply pressing a button. The messages, which are stored by Global Connect in order to keep your telephone system functioning effectively, can be retrieved at our convenience.

Since the Global Connect system is 100% web-based, a messaging campaign can be deployed from any location, at any time of the day or night. As long as you have access

to a telephone or computer with Internet access, you can call your contacts, no matter how extreme the emergency.

The cost of this system will cost the Town $.50 per household. With a population of approximately 4,300, Global Connect translates that into approximately 1,700 households. With those numbers, using this system would cost the Town approximately $850.00 per year. Global Connect advised me that they are currently providing a nine month free trial with no obligation to sign on.

One issue that Council needs to consider is how to obtain the database needed for these notifications. Global Connect recommends purchasing the telephone number database from our phone provider, Verizon. This database is only available to municipalities such as the Town. In the database would be all telephone numbers on the Island, including unlisted, unpublished, and telephone numbers on the "do not call" list. According to Global Connect, it is ok for the Town to send out "emergency" calls to any number in the database, however; it would not be permitted to send out "non emergency" calls to the "restricted" numbers above without the phone customers permission. Global Connect advised that there are several ways to obtain this permission if the Town wanted to. Global Connect said that the cost of our database from Verizon should cost approximately $1,400.00, a one time cost.

Global Connect's representative advised me that there have been other municipalities who attempted various, aggressive sign up campaigns with only approximately 20% of residents signing on.

I have attached three documents obtained from Global Connect's web site in which the Council can see some of the benefits and uses of this type of "reverse 911 system".

Emergency Notification

When seconds count, choose Global Connect.

In an emergency situation, you may need to reach first responders, other staff me volunteers, and residents, quickly and easily. With unsurpassed speed and capaci Global Connect allows you to reach thousands of contacts each minute.

From storms that threaten the coastline to uncontrollable forest fires, some crises certain geographical region harder than others. In those cases, you can take adva of Global Connect's mapping capability to create a customized list of call recipient your map. Simply select the area affected by the emergency at hand, and the syst will develop the list of telephone numbers for the residents in that area.

Global Connect's real-time reporting feature allows you to see instantly who has received your message, and the system lets you decide how often and how many you will retry the call. With our Direct-Connect to Dispatch feature, residents can c the dispatch center with the touch of a button to confirm their condition or request information. The system also allows residents to leave a detailed message by sim pressing a button. The messages, which are stored by Global Connect in order to your telephone system functioning effectively, can be retrieved at your convenienc

Since the Global Connect system is 100% web-based, a messaging campaign cai deployed from any location, at any time of the day or night. As long as you have a to a telephone or computer with Internet access, you can call your contacts, no ma how extreme the emergency.

Press Release

Contact: Chief Bernard F. Lombardo
Ringwood Police Department
973-962-7017

New Emergency Notification System in Ringwood and Wanaque already paying dividends.

On Wednesday May 21,2008 a six year old boy was reported missing in a wooded area near Snake Den Road in Bloomingdale. This road is located in a remote area that borders Norvin Green State Forest as well as North Jersey District Watershed property. Ringwood is contracted to supply emergency services to the Bloomingdale residences in this area. While Bloomingdale Police and the Passaic County Sheriff's Department were coordinating the search effort, Lt. Gary Bertsch of the Ringwood Police Department and Capt Thomas Norton of the Wanaque Police Department worked together to send an emergency message to the residents in the area of the missing child.

Shortly after the messages were released numerous residents arrived at the Command post and offered assistance. Paula Roll, a resident of Snake Den Road heard the message and initiated a search on her own in the wooded area behind her home. Paula located the missing child in a swampy area and then walked him to a trail where they met up with Ringwood Police Officers Ron Porta and James Rapp and Bloomingdale Officer Neal Keegstra. The child was then returned to his parents, thankfully unharmed.

The Emergency Notification System, supplied through a company, Global Connect of Mays Landing, NJ, was purchased by Ringwood and Wanaque recently. Both municipalities negotiated and purchased the system at the same time thus saving costs to the taxpayers. The emergency notification system has been tested in both municipalities. Ringwood and Wanaque Police want to remind and encourage the residents that they can register additional phone numbers by going to the respective Borough's web site and clicking on to the link.

Your Weekly Hometown Newspaper
The Manchester Times

"Reverse 911" System Can Get Word Out During Emergencies

By Christina Cuesta

In Manchester, 911 can now call *you* in the case of an emergency.

A newly activated Global Connect system is described as a "reverse 911 program that, if there is an emergency of some kind, we can get a message out to residents who need to know about it first," business administrator Constance Lauffer said.

The new system allows a message to be recorded and sent by phone to all residents whose numbers are listed through Verizon. In case of a storm, forest fire, water main break or other serious emergency, residents in any specific area of the township can be notified "so people aren't wondering what is going on or what they should be doing," Lauffer said.

A recent test of the Global Connect system was a success. It included about 70 members of a volunteer Community Emergency Response Team, or CERT, who received a three-minute message with the new system. The calls went out in 15 minutes and only three did not receive a message because of wrong listing. Every other place where there was a person or an answering machine received the test message.

"We will not be using it to bother you," Lauffer continued, citing that messages about concerts at Whiting lake or recreation camp will not be what the Global Connect system is for. "The point is to let you know about things of an important nature that can involve a dangerous situation or a township service that is timely."

Manchester Police as well as the public works department plan on using the system to contact employees for work during such crises like snow storms.

After much deliberation about which provider to use, administrator's chose a Global Connect system, which cost $11,000.

"We are very pleased with what we have come up with and think it is a true service to the community," Lauffer said.

MEMORANDUM

To: Mayor & Council

From: Jared B. Anderson

Date: June 16, 2009

Subject: Wind Energy Systems

The Planning Commission has discussed on several occasions wind energy systems (i.e. windmills, or wind turbines) especially those residential in nature. Currently, all the districts allow 'power generating windmills' only by special exception through the BZA. In the past couple of meetings they have discussed how wind energy systems could be permitted, how to site them, how tall they should be, the insurance required, and many other issues. Our current zoning ordinance is very vague in regards to 'power generating windmills,' there is not even a definition for this use-type.

At the May 26th, 2009 Planning Commission Meeting the commissioners made a motion to send the 'idea' of establishing a wind energy system ordinance to the Mayor and Council to get their thoughts on the 'idea.' If the Mayor and Council thought it was a concept that deserved more attention the Planning Commission could make revisions, if needed, and send the issue to public hearing, after which time an official recommendation would be sent to Council.

If Council so desires a motion could be "for the Planning Commission to continue to develop a wind energy systems ordinance, hold a public hearing, and send their recommendations back to Council for review."

Please see the attached ordinance which is a draft and has not been through any public hearings at this time.

Zoning Ordinance

Article VI

Section F. Wind Energy Systems

6.9 The purpose of the article is to regulate the placement, construction, and modification of small wind energy systems while promoting the safe, effective, and efficient use of small wind energy systems.

Section 6.9.1 Applicability

The requirements set forth in this section shall govern the siting of small wind energy systems used to generate electricity or perform work which may be connected to the utility grid pursuant to the Virginia's net metering laws, serve as an independent source of energy, or serve in a hybrid system.

Section 6.9.2 Siting Requirements

The requirements for siting and construction of all small wind energy systems regulated by this section shall include the following:

1) Small wind energy towers shall maintain a galvanized steel finish, unless FAA standards require otherwise, or if the owner is attempting to conform the tower to the surrounding environment and architecture, in which case it may be painted to reduce visual obtrusiveness. A photo simulation may be required at the request of the Mayor and Council.
2) Small wind energy systems shall not be artificially lighted unless required by the Federal Aviation Administration (FAA) or appropriate authority.
3) No tower should have any sign, writing, or picture that may be construed as advertising by the building and zoning administrator or their designee.
4) A Small wind energy system shall be located on a parcel that, at minimum is ½ acre in size.
5) The applicant shall provide evidence that the proposed height of the small wind energy system tower does not exceed the height recommended by the manufacturer or distributor of the system.
6) The applicant shall provide evidence that the provider of electric utility service to the site has been informed of the applicant's intent to install an interconnected customer-owned electricity generator, unless the applicant intends, and so states on the application, that the system will not be connected to the electricity grid. This notification will take place by having the electric utility provider sign the conditional use permit application. This signature does not construe approval for net metering by the electric utility.
7) Small wind energy systems shall not exceed sixty (60) decibels, as measured at the closest property line. The level, however, may be exceeded during short-term events such as utility outages and/or severe windstorms.

8) The applicant will provide information demonstrating that the system will be used primarily to reduce on-site consumption of electricity.
9) The tower height shall not exceed a maximum height of seventy (70) feet on a parcel.
10) The minimum distance between the ground and any protruding blade utilized on a small wind energy system shall be fifteen (15) feet, as measured at the lowest point of the arc of the blades. The lowest point of the arc of the blades shall also be ten feet above the height of any structure within seventy-five (75) feet of the base. The supporting tower shall also be enclosed with a six-foot tall fence or the base of the tower shall not be climbable for a distance of ten (10) feet.
11) The applicant will provide proof of adequate liability insurance for a small wind energy system. Whether or not the applicant is participating in the net metering program, the applicant will be required to meet the insurance coverage requirements as set forth in 20 VAC 5-315-60.
12) The small wind energy system generators and alternators should be constructed so as to prevent the emission of radio and television signals and shall comply with the provisions of Section 47 of the Federal Code of Regulations, Part 15 and subsequent revisions governing said emissions.

Section 6.9.4 Review process

The property owner will adhere to the conditional use permitting process as provided by Article IX of the Town of Chincoteague's Zoning ordinance.

Section 6.9.5 Federal and state requirements

1) Compliance with the Uniform Statewide Building Code: Building permit applications for wind energy systems shall be accompanied by standard drawings of the wind turbine structure, including tower, base, and footings, An engineering analysis of the tower showing compliance with the Uniform Statewide Building Code and certified by a licensed professional engineer shall also be submitted.
2) Compliance with FAA Regulations: Wind energy systems must comply with applicable FAA regulations including any necessary approvals for installations close to airports.
3) Compliance with National Electric Code: Building permit applications for wind energy systems shall be accompanied by a line drawing of the electrical components in sufficient detail to allow for a determination that the manner of installation conforms to the National Electrical Code.
4) Compliance with regulations governing energy net metering: Wind energy systems connected to the utility grid must comply with the Virginia Administrative Code 20 VAC 5-315: Regulations Governing Energy Net Metering.

Section 6.9.6 Setbacks

The wind energy system shall be set back a distance at least equal to one hundred ten (110) percent of the height of the tower plus the blade length from all adjacent property lines and a distance equal at least to one hundred fifty (150) percent of the tower height plus blade length from any dwelling

inhabited by humans on neighboring property. These setbacks may be reduced by notarized consent of the owner of the property on which the requested wind energy system is to be erected and the adjacent landowner whose property line or dwelling falls within the specified distance. Additionally such adjacent landowner must execute a deed of easement for the benefit of the property on which the wind energy system is to be erected prohibiting construction of any new structure on such adjacent property within the specified easement. Wind energy systems shall meet all setback requirements for primary structures for the zoning district in which the wind energy system is located in addition to the requirements set forth above. Additionally no portion of the small wind energy system, including guy wire anchors may be extended closer than ten (10) feet to the property line.

Section 6.9.6 Removal of defective or abandoned wind energy systems

Any wind energy system found to be unsafe by the building official shall be repaired by the owner to meet federal, state and local safety standards or removed within six (6) months. Any wind energy system that is not operated for a continuous period of twenty-four (24) months shall be considered abandoned and the owner of the system shall remove the turbine within ninety (90) days of receipt of notice from the town instructing the owner to remove the abandoned wind energy system.

TOWN OF CHINCOTEAGUE
STREET NAME REQUEST

APPLICANT: DONALD RAY THORNTON PHONE: 336-5200

ADDRESS: 5384 DEEP Hole Rd.

PROPOSED STREET NAME: PINE GROVE WAY

IF ABOVE PROPOSED STREET NAME IS DENIED, LIST A SECOND CHOICE:
SALT POND DR.

OWNER OF ABOVE STREET: DONALD RAY THORNTON

LIST ALL PROPERTY OWNERS THAT ADJOIN THE PROPOSED STREET TO BE NAMED AND THEIR APPROVAL OR DISAPPROVAL OF THE ABOVE REQUEST:

(✓) APPROVE ( ) DISAPPROVE

NAME: DONALD RAY THORNTON PHONE: 336-5200

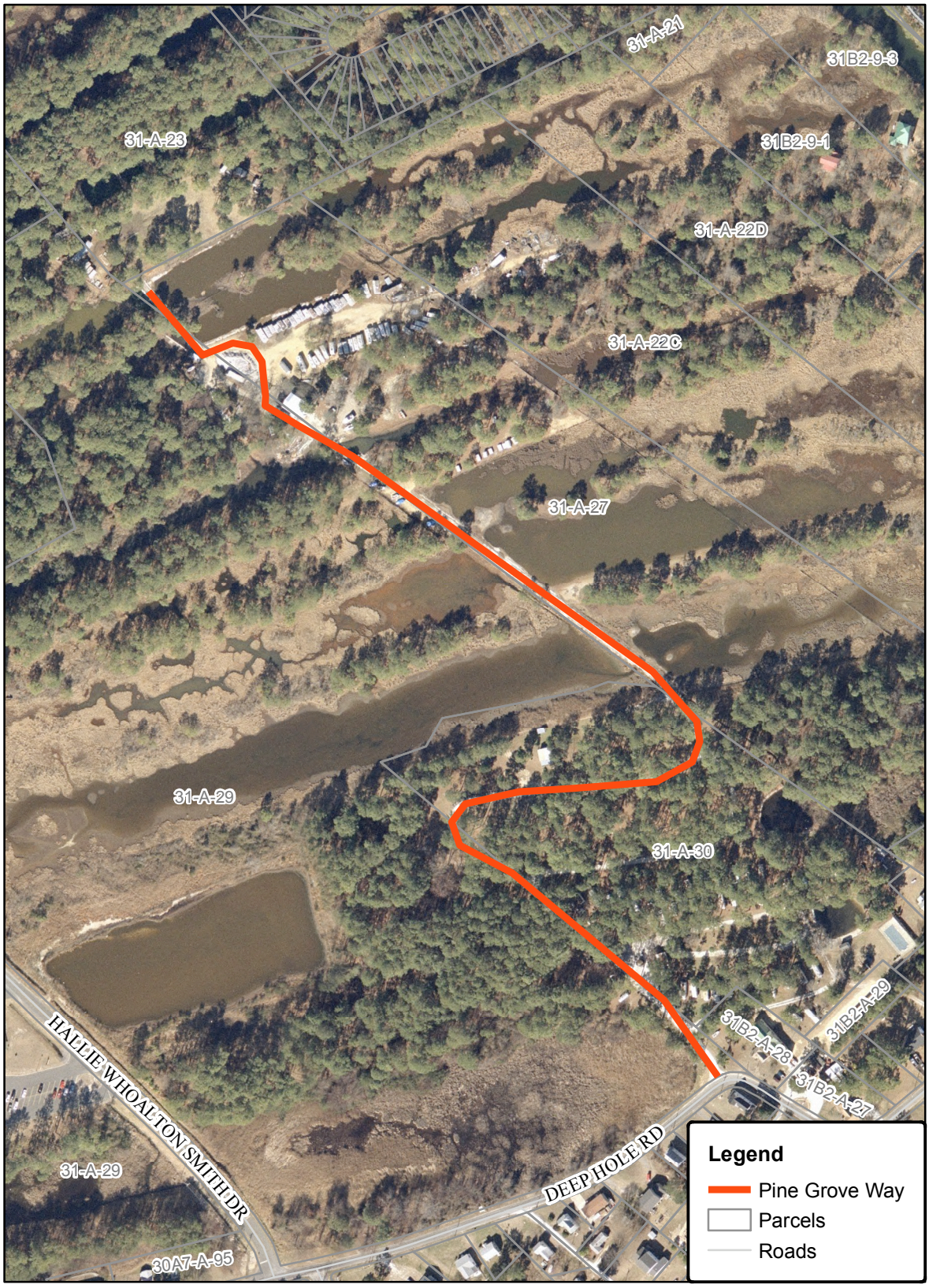
ADDRESS: 5384 DEEP Hole RD

( ) APPROVE ( ) DISAPPROVE

NAME: _____ PHONE: _____

ADDRESS: _____

Pine Grove Way



0 0.05 0.1 0.2 Miles